

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

00784

1. PLACE OF DEATH

County Jules AnneVillage or City Chester (Rural)

No.

St.

Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word)

married

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE ofJohn. H. Aytch

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than

1 day, --- hrs.
or --- min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

Stevensville md

FATHER

13. NAME

John R. Robinson

14. BIRTHPLACE (city or town) (State or country)

Stevensville md

MOTHER

15. MAIDEN NAME

Josephine Robinson

16. BIRTHPLACE (city or town) (State or country)

Stevensville md

17. INFORMANT

(Address)

Chester, md.

18. BURIAL, CREMATION, OR REMOVAL

Place

Chester md.

Date

Jan. 24, 19. 45

19. UNDERTAKER

(Address)

Louis Henry Cambridge

20. FILED

Date

Feb 2nd, 1945L. C. Thomas

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

January
(Month)21
(Day)1945
(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1944, to Jan 21, 1945I last saw her alive on Jan 20, 1945; death is saidto have occurred on the date stated above, at 7:15 a m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

acute interstitial nephritis.

Date of onset

Nov 1945

Other Contributory Causes of Importance

Cerebral Arteriosclerosisabout 5 years

Name of operation

none

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

no

If so, specify

(Signed)

(Address)

Samuel J. Quill
Quill-Starns

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

00785

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, institution, or street address where death occurred:
Tidwell Ave
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Charleston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.R. #
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Bertha Mae Baxter

3. (b) Social Security Number

-

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife J. Albert Baxter7. Birth date of deceased (mo., day, yr.) July 10 1897 6. (c) If alive, give age 50 years8. AGE: Years 47 Months 6 Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Near Centerville, Queen Anne's Co. Md.
(Town, county, and state)10. Usual occupation housewife11. Industry or business home12. Name Wm Franklin Baxter13. Birthplace Centerville Md.14. Maiden name Martha Davis15. Birthplace Centerville Md.16. Informant Mr. J. Albert Baxter (Husband)Address Charleston, Md.17. Burial Date thereof 1/14/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CharlestonLocation Charleston Maryland19. Funeral director Marvin B. WilliamsAddress Charleston Maryland19. 1-11- 19 45 Elie Armstrong

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1945 at 7:20 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 to Jan 11 1945and that I last saw him alive on Jan. 10 1945

Immediate cause of death _____ DURATION _____

Due to hemorrhage _____Due to metastasis _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. B. Williams M. D. or other _____Address Charleston, Md. Date signed 1-11/45

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00786

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne
City or town Rural Centerville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Queen Anne
City or town Rural Centerville
(If outside city or town limits, write RURAL and give nearest town)
Street No. (Brownsville)
(If rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAME

Alexander Brown

3. (b) Social Security Number

none

4. Sex Male 5. Color or race Caucas 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Carrie ?
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) 1879
8. AGE: Years 66 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Brownsville 2d. Md
(Town, county, and state)

10. Usual occupation Farm Land

11. Industry or business

12. Name Thomas Brown

13. Birthplace Brownsville 2d. Md

14. Maiden name Ellen Ryan

15. Birthplace Brownsville 2d. Md

16. Informant Mamie Harris

Address Centerville Maryland

17. Buried Date thereof Jan 26-45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Brownsville

Location Brownsville Maryland

18. Funeral director Barton Bros

Address Centerville Maryland

19. 1-26-45 Elin Armstrong
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 19 45 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 19 44 to Jan 24 19 45
and that I last saw h. _____ alive on _____ 19 _____

Immediate cause of death Myocardial Regeneration

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE W. Henry Frasier

Address Centerville Md M. D. or other _____

Date signed Jan 5-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Bergen
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3.(a) FULL NAME

Percy A. Clark

3.(b) Social Security Number

214-12-6277

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Jan 21 - 1903

8. AGE: Years 41 Months 11 Days 22 If less than one day hrs. _____ min. _____

9. Birthplace Stevensville 2 a.c. Md.
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business Jerry Clark12. Name Jerry Clark13. Birthplace Stevensville, Md.14. Maiden name Beatrice Thomas15. Birthplace Stevensville, Md.16. Informant Mrs. Helen E. WalkerAddress Centerville Md.17. Burial Date thereof Jan 12 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory StevensvilleLocation Stevensville Md.18. Funeral director Barton BrosAddress Centerville, Md.19. Jan 12 - 19 45 Elie Armstrong
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 19 45 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____, and that I last saw him _____ alive on _____ 19_____.
 Immediate cause of death Asphyxiation - fire, coal oil furnace in fire.

Due to Asphyxiation - fire, coal oil furnace in fire.
 Due to Asphyxiation - fire, coal oil furnace in fire.
 Other conditions Third degree burns.
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of Jan 12 '45
 Where did injury occur? Centerville (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) at home
 Means of injury Asphyxiation of Injured at work? no.

23. SIGNATURE Samuel Price M.D.
deputy medical examiner
 Address Centerville, Md. Date signed Jan 12 1945

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FEB 5 1945

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-1)

00788

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen AnneCity or town Kingston
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Queen AnneCity or town Kingston
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Thomas Cranor

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowedB. (b) Name of husband or wife Ada Cranor

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1859

8. AGE: Years Months Days If less than one day

85812

..... hrs. min.

9. Birthplace Cecil Co. Maryland
(Town, county, and state)10. Usual occupation Farmer (retired)

11. Industry or business

12. Name Eli P. Cranor13. Birthplace Md.14. Maiden name Annie Shelton15. Birthplace Md.16. Informant Miss. Bessie DwyerAddress Chestertown, Md. (R.F.D.)17. Burial Date thereof Jan. 4, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Crumpton Cem.Location Crumpton, Md.18. Funeral director J. Willis WellsAddress Chestertown, Md.19. Jan. 3 1945 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1945 at 6.9 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-15 1944 to 1-1 1945and that I last saw him alive on 1-1 1945Immediate cause of death Organic heart trouble

DURATION

Due to Regurgitation

Due to

Other conditions NPP

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H P Caheland MD M. D. or otherAddress Chestertown Date signed 1-2-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

00789
Reg. Dist. No. 251

1. PLACE OF DEATH

County Queen Anne
City or town Barclay Ind.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 1/2 yrs
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Queen Anne
City or town Barclay
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Nathaniel E. Crossman

3. (b) Social Security Number

4. Sex F Color or race W 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband or wife Edmund S. Crossman7. Birth date of deceased (mo., day, yr.) Aug 26, 1889 8.(c) If alive, give age years

8. AGE: Years 55 Months 5 Days 5 If less than one day
hrs. min.

9. Birthplace Pa. Co
(Town, county, and state)10. Usual occupation H. W.

11. Industry or business

12. Name Ed. Price13. Birthplace Caroline Co14. Maiden name Mary Emma Loney15. Birthplace Huntersville16. Informant W. E. EidersAddress Price, Ind.17. Burial Date thereof Jan. 23, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sudlersville Cem.Location Sudlersville Ind.18. Funeral director Edgar L. LaneAddress Church Hill Ind.19. Jan. 21 19 45 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 19 45 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 45 to Jan 20 19 45
and that I last saw him alive on Jan 20 19 45

Immediate cause of death

Coronary occlusionDue to Grav. Arterial SclerosisDue to Dealted MyocarditisOther conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE @ H. Upetelle M. D. or otherAddress Fachville Ind. Date signed 1/22/45

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BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

00790

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: *Green Anne*
County *Mr. Centreville*
City or town *Centreville*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *15 yrs*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *Maryland* County *Green Anne*
City or town *Centreville R.F.D.*
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war ☒

3. (a) FULL NAME *Martha Belle Harrison*

3. (b) Social Security Number ☒

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Jan 31 - 1870* 6. (c) If alive, give age _____ years

8. AGE: Years *74* Months *11* Days *11* It less than one day _____ hrs. _____ min.

9. Birthplace *Williamsport, D.C. Co., Md*
(Town, county, and state)

10. Usual occupation *Housekeeping*

11. Industry or business

FATHER 12. Name *William Harrison* 13. Birthplace *D.C. Co*

MOTHER 14. Maiden name *Amanda Price* 15. Birthplace *Green Anne Co*

16. Informant *Mr. Joseph Bishop*
Address *Centreville, Md*

17. *Burial* Date thereof *Jan 13 - 45*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Greenmount*
Location *Williamsport - Md*

18. Funeral director *Barton Bros*
Address *Centreville, Md*

19. *1-13-* 19 *45* *Elie Armstrong*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 10* 19 *45* at *10:50 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 4* to *Jan 10* 19 *45* and that I last saw him *4* alive on *Jan 4* 19 *45*.

Immediate cause of death _____ DURATION _____

Due to *Hypertension*

Due to *Hypertension*

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *H. H. Harrison* M. D. or other _____

Address *Centreville, Md* Date signed *1/14/45*

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FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age of deceased is shown on

FILM No. G 93 MAR 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

00791

Reg. Diat. No. 254

1. PLACE OF DEATH:

County Queen Anne's
City or town Grasonville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all of life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Queen Anne's
City or town Grasonville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mary Elizabeth Heath

3.(b) Social Security Number

none

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Chas Heath (deceased)

7. Birth date of deceased (mo., day, yr.) June 10-1876 6.(c) If alive, give age 67 years

8. AGE: Years 68 Months 7 Days 18 If less than one day
hrs. min.

9. Birthplace Grasonville Md
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business

Widow

12. Name Widow

13. Birthplace Grasonville Md

14. Maiden name Widow Griffin

15. Birthplace Grasonville Md

16. Informant Widow Griffin

Address Grasonville Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 30-45
(month) (day) (year)

Cemetery or crematory Brynn Chapel Churchyard

Location Grasonville Md

18. Funeral director John D. Williams

Address Grasonville Md

19. Jan. 30 45 H M Adridge
(Date rec'd by registrar) R.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28-1945 at 3:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased Jan 10 1944, Jan 28 1945
and that I last saw him alive on Jan 27 1945.

Immediate cause of death

Arteriosclerosis

Due to Angina pectoris

Due to Coronary Sclerosis with

Other conditions coronary occlusion

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Theodor Sattelmaier

Address Stevensville M. D. or other

Date signed Jan 29 1945

DURATION

about 2 years

6 months

2 days

UNITED STATES DEPARTMENT OF JUSTICE

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FEB 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(942)

00792

CERTIFICATE OF DEATH

Reg. Dist. No. 25-3

1. PLACE OF DEATH:

County Queen AnneCity or town near Stevensville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John M. Holder

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ruth A. Holder

7. Birth date of deceased (mo., day, yr.)

May 3 - 18888. (c) If alive, give age 50 years

8. AGE:

Years

Months

Days

If less than one day

567hrs.min.

8. Birthplace

Queen Anne Co
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

James E. Holder

13. Birthplace

Q. A. Co

14. Maiden name

Emma May Covey

15. Birthplace

Q. A. Co

18. Informant

Mrs. Ruth Holder

Address

near Stevensville

17.

Burial
(Burial, cremation, or removal, which?)

Date thereof

Jan 4 - 45
(month) (day) (year)

Cemetery or crematory

Stevensville

Location

Stevensville Md

18. Funeral director

Edgar L. Lane

Address

Chick Hill

19.

45
(Date rec'd by registrar)

19.

L. C. Thomas

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Queen Anne

City or town

near Stevensville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 1, 1945 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

18

Immediate cause of death

Proseny Occlusion

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Samuel Price M.D.
deputy medical examiner M. D. or other

Address

Stevensville

Date signed

1/1/45

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECORDED

FEB 10 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 23-3

1. PLACE OF DEATH:

County... Queen Anne'sCity or town... Stevensville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Queen Anne'sCity or town... Stevensville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Emma Frances Legg

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Wm. H. Legg

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Jan. 10 - 1862

8. AGE: Years Months Days If less than one day

83 0 13 hrs. min.

9. Birthplace

Greensboro - Caroline - Ind.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

John S. Russum

13. Birthplace

Caroline Co. Ind.

14. Maiden name

Angelina Jarman

15. Birthplace

Caroline Co. Ind.

16. Informant

Mrs. Russum Legg

Address

Stevensville Ind.

17. Burial

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Stevensville Cem.

Location

Stevensville Ind.

18. Funeral director

Edgar L. Lane

Address

Church Hill Ind.19. 1, 23 45 Fe C. Thomas

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 19 45 at 3 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 22 19 45 to Jan. 23 19 45and that I last saw him ✓ alive on Jan. 23 19 45

Immediate cause of death

coronary thrombosisDue to myocardial degenerationDue to general arteriosclerosisOther conditions cerebral embolism withhemiplegia

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Theodor Sattelmayer M.D.Address Stevensville M. D. or otherDate signed Jan. 23. 45

DURATION

1 dayabout3 yearsabout10 years1943+ 1944

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

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AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

RECEIVED

FEB 6 1945

BUREAU V.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00794

Reg. Dist. No.

251

1. PLACE OF DEATH:

County QUEEN ANNE
City or town SANDTOWN NE SW ALERSVILLE
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: LETT NURSING HOME
Stay in hospital or inst. (yrs., or mos., or days) 10 MONTH
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County KENT
City or town CHESTERTOWN Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Elmer Watkins Hewston

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower

6 (b) Name of husband or wife Rose Hewston

Married 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-19-1892

8. AGE: Years Months Days If less than one day
52 5 29 hrs. min.

9. Birthplace Kent County
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Joseph Edwards Hewston

13. Birthplace Kent County

14. Maiden name Catherine Ward

15. Birthplace Kent County

16. Informant Anna Hewston Sister

Address Chestertown, Md

17. Buried Date thereof 1-20-1945
(Burial, cremation, or disposal) (month) (day) (year)

Cemetery or crematory Chester

Location Chestertown, Maryland

18. Funeral director J. Willis Wells

Address Chestertown, Md

19. Jan. 19 45 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1945, at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Jan 18 1945, and that I last saw him alive on Jan 18 1945.

Immediate cause of death

Myocardial Infarction

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

G. L. Coffman

M. D. or other

Address Mallorys Date signed Jan 18 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 7 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

00795

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County... QUEEN ANNE
City or town... NA SUDLESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

PALMDISTORY NURSING HOME
How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Queen Anne

City or town... Sudlersville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

LILLIAN BENTON PRICE

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Widowed

6.(b) Name of husband or wife... LEVE PRICE

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1879

8. AGE: Years 65 Months 3 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation... nurse

11. Industry or business

12. Name... L. C. BENTON

13. Birthplace MARYLAND

14. Maiden name... HENRIETTA PANDEE

15. Birthplace MARYLAND

16. Informant L. Homer Benton

Address Sudlersville, Md

17. Burial, cremation, or removal, Which? Burial Date thereof Jan. 3 1946
(month) (day) (year)

Cemetery or crematory Sudlersville, Cen.

Location Sudlersville, Md

18. Funeral director J. Willis Wells

Address Chestertown Md

19. Jan. 2 1945 Edgar L. Lane

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1945 at 1230 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 15 1944 to Jan. 1 1945

and that I last saw him alive on Dec 28 1944

Immediate cause of death

Carcinoma of Breast

Due to

Due to Cachexia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. T. Wells

Address Sudlersville Md. B. or other

Date signed Jan. 1 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC

FEB 7 1945

BUUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Diat. No. 10252

1. PLACE OF DEATH:

County Queen Anne'sCity or town Centreville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Centreville
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural - Wayden
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy Scott

3. (b) Social Security Number

4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 19, 1945 8. (c) If alive, give age 7 years8. AGE: Years Months Days If less than one day 7 hrs. 30 min.9. Birthplace Centreville, Queen Anne's Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name Lorraine Scott15. Birthplace Centreville Md.16. Informant Lorraine ScottAddress Centreville Md.17. Disposed of by Parent Date thereof Jan 20, 1945
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory at homeLocation nr. Centreville

18. Funeral director

Address Centreville, Md.19. 5-24-45
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 19 45, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 19 45 to Jan 19 19 45
and that I last saw him alive on Jan 19 19 45Immediate cause of death anoxemia

DURATION

6 hDue to Premature 2nd

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C.R. Layton MDAddress Centreville Md M. D. or otherDate signed Jan 20, 1945

CERTIFICATE OF DEATH

RECEIVED

FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 115-6

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

County Queen AnneCity or town Stevensville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen AnneCity or town Chester
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

William Henry Williams

3. (b) Social Security Number

none4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Carric Chick Hagler6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) Jan 14 - 18738. AGE: Years 71 Months 11 Days 22 It less than one day _____ hrs. _____ min.9. Birthplace Treestown Wales
(Town, county, and state)10. Usual occupation Retired Contractor11. Industry or business Heating & Plumbing12. Name John Williams13. Birthplace Treestown Wales14. Maiden name Hennetta Butler15. Birthplace England16. Informant Grace M WilliamsAddress 1800 N. Charles St Baltimore17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 8 - 45
(month) (day) (year)Cemetery or crematory ParkwoodLocation Legler Ave Talbot County18. Funeral director Talbot, TalbotAddress Centerville Maryland19. Date read by registrar 6-6 19 45 Registrar F.C. Thomas

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 19 45 at 6 30 P.M.21. I CERTIFY that death occurred on the data above stated; that I attended deceased from Dec. 31 19 44 to Jan. 5 19 45.and that I last saw him alive on Jan. 5 19 45.

Immediate cause of death _____ DURATION _____

acute pyelitis and 5 daysDue to nephritisacute uremia 2 dayDue to hemolytic strept.Other conditions coccus throat 4 day

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Theodor Sattelmeier M. D. or other _____Address Stevensville Date signed 1/5/45

RECEIVED
JAN 30 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County... Queen Anne
 City or town... Centerville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... 200

City or town... Centerville
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

"Baby" Wilmer

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Caucas

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Jan 2 - 1945

8. AGE:

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace

Centerville 200 Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Calvin Wilmer

13. Birthplace

Centerville Maryland

MOTHER

14. Maiden name

May Ellen Brown

15. Birthplace

in Centerville Md

16. Informant

Address

Calvin Wilmer
Centerville Md

17.

(Burial, cremation, or removal Which?)

Date thereof

Jan 3 - 45
(month) (day) (year)

Cemetery or crematory

Location

Punite
in Centerville Maryland

18. Funeral director

Address

Barton Bros
Centerville Md

19.

1 - 3 - 45
(Date rec'd by registrar)

19.

45

Chie Armstrong
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945 at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2 - 45 to Jan 3 - 45and that I last saw him alive on Jan 25 1945

Immediate cause of death

Premature birth (6 mo.)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Fraker

M. D. or other

Address

Centerville Md

Date signed

1/3/45

RECEIVED

FEB 5 1945

BUREAU V.S.